

**Island View Dental**  
**638 North Webb Rd**  
**Grand Island, NE. 68803**  
**(308) 381-0167/ Fax (308) 381-6689**

**PATIENT PAYMENT OPTIONS**

Patient Name \_\_\_\_\_ Initial Date \_\_\_\_\_

**Pre-Payment for Entire Treatment Plan:** Total Treatment: \$ \_\_\_\_\_

- Total Treatment Plan, by Credit Card: \$500- \$1500= 3% Savings      Total \_\_\_\_\_
- Total Treatment Plan, by Cash or Check: \$500- \$1500 = 5% Savings      Total \_\_\_\_\_
- Total Treatment Plan, by Credit Card: \$ 1501+ = 7% Savings      Total \_\_\_\_\_
- Total Treatment Plan, by Cash or Check \$1501+ + 10% Savings      Total \_\_\_\_\_
- Practice will submit insurance for patient reimbursement

**Pay as You Go for Each Treatment:**

- Total patient responsibility (co pay) paid at time of service by cash, check or credit card

**1/2 - 1/2**

- 1/2 of total fee/ Co payment at first treatment      Amount \_\_\_\_\_ Date \_\_\_\_\_
- Remaining 1/2 of total fee/ Co payment at agreed upon date      Amount \_\_\_\_\_ Date \_\_\_\_\_

**1/3 - 1/3 - 1/3**

- 1/3 of Total Treatment Fee/ Co payment=Prepayment      Amount \_\_\_\_\_ Date \_\_\_\_\_
- 1/3 of Total Treatment Fee/ Co payment at first Treatment date      Amount \_\_\_\_\_ Date \_\_\_\_\_
- 1/3 of Total Treatment Fee/ Co payment at final Treatment Date      Amount \_\_\_\_\_ Date \_\_\_\_\_

**Payment over 3, 6, or 12 months (Interest Free) minimum of \$300**

- 0% financing for 3, 6, or 12 months      Monthly payment \_\_\_\_\_
- Practice pays the interest carried through      for \_\_\_\_\_ months
- third-party company

**Extended payment option (Interest Applies) minimum of \$1000**

- The above company also offers 24, 36, 48, and 60 month payment plans
- Patient pays all interest

Total \$ \_\_\_\_\_

Estimated Patient Portion \$ \_\_\_\_\_ over \_\_\_\_\_ months

**IMPORTANT:** Insurance portion is an estimated amount. Payment may vary based upon the patient's deductible and plan limitations.

This is to certify the above treatment fees and checked payment option has been explained to me and I fully understand the nature of the treatment recommended. I understand and agree that if my insurance does not pay my insurance claim within 45 days, I am responsible for any balance due. I agree to pay reasonable attorney's fees, court costs and collection costs incurred by \_\_\_\_\_ in collection and enforcement of the debt. The above fees will be honored for 90 days or until commencement of treatment, whichever occurs first.

Accepted: \_\_\_\_\_ Date: \_\_\_\_\_

Financial Coordinator: \_\_\_\_\_